Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gurjeet Kalra MD

Respondent Name
Cherokee Insurance Co

MFDR Tracking Number
M4-14-0232-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
September 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… it is our position that Cherokee insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to (claimant)."

Amount in Dispute: $1,340.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As this treatment was not administered for the compensable injuries, and because the Carrier is obligated to pay (or not pay) benefits in accordance with the Designated Doctor's opinion, pursuant to Tex. Lab. Code §408.0041(f), no reimbursement for these services is owed."

Response Submitted by: Adami, Shuffield, Scheihing, & Burns

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2012	99204	$1,340.00	$0.00
January 2, 2013	99213		
January 16, 2013	99213		
January 30, 2013	99213		
February 13, 2013	99213		
March 13, 2013	99213		
April 17, 2013	99213		
May 15, 2013	99213		
June 26, 2013	99213		
July 24, 2013	99213		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 sets out definition of terms adopted by the Division related to medical billing and processing for health care services.

3. 28 Texas Administrative Code §133.200 sets out guidelines for insurance carriers receipt of medical bills.
4. 28 Texas Administrative Code §133.204 sets out guidelines related to paper explanation of benefits.
5. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
6. The services in dispute were returned as unprocessable by the respondent with the following reason codes:
   - Claim has been disputed, please submit to the patient's private insurance carrier.
   - Other: Treatment is related to disputed/non-compensable conditions.

Issues

1. Did the requestor meet the Division guidelines for submitting a complete bill?
2. Did the respondent comply with Division rules upon receipt of disputed services?
3. Did the respondent comply with Division rules when responding to the health care provider?
4. Did the respondent raise a new denial reason?
5. Did the requestor support services billed with medical documentation?
6. Is the request eligible for reimbursement?

Findings

1. 28 Texas Labor Code §133.2(4) states in pertinent terms, "Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing). Review of the submitted documentation finds no rejection by the carrier as incomplete. Therefore, the claim will be processed in compliance with Division rules and guidelines.

2. 28 Texas Labor Code 133.200(a) states in pertinent part, "Upon receipt of medical bills…, an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2…" (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. (b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item. Review of the submitted documentation finds, the carrier returned the disputed medical bill that was not a duplicate claim nor was a line item reason given on the document created by the carrier. The Division finds the carrier did not comply with guidelines of 28 Texas Labor Code §134.2. The disputed services will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §133.240(f) defines what must be contained on paper form of an explanation of benefits. Review of submitted documentation finds the carrier did not comply with Division rules. The disputed services will be reviewed per applicable rules and fee guidelines.
4. 28 Texas Administrative Code §133.307(d)(2)(F) states in pertinent part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. Review of the submitted documentation finds the carrier corresponded with the health care provided stating the medical bills had been unprocessable. Also, the documents sent did not meet the Division requirements of an Explanation of Benefits. Therefore, the carrier's statement in their response to MFDR is considered a new denial reason and will not be considered as part of this review.
5. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;…" Review of the submitted medical bills find the requestor submitted CPT codes 99204 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family", for date of service December 19, 2012. The medical documentation submitted with this dispute is titled, "Initial Psychiatric Evaluation". For remaining dates of service, CPT code 99213 was submitted, "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the

patient and/or family." Review of the submitted medical documentation finds all documents titled, "Psychiatric Follow-Up." Therefore, the division finds the requestor did not support the services as billed.

6. Requirement of Rule 134.203 not met. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Peggy Miller	June 25, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.